COMMUNITY TITLE COMPANY

# STATE BOARD OF HEALTH

Local No. 126 FILE NO. 16789 **CERTIFICATE OF DEATH**

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

June 4, 1990 — Date Issued

Franklin D. Penuela M.D. — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1 DECEASED—NAME (First, Middle, Last): Edward Bryson

2 SEX: Male

3a TIME OF DEATH: 9:55 p.m.

3b DATE OF DEATH (Month, Day, Yr): February 7, 1990

4 SOCIAL SECURITY NUMBER: 313-01-6475

5a AGE—Last Birthday (Years): 71

5b UNDER 1 YEAR (Months, Days):

5c UNDER 1 DAY (Hours, Minutes):

6 DATE OF BIRTH (Mo., Day, Yr.): Oct. 30, 1918

7 BIRTHPLACE (City and State or Foreign Country): Detroit, Michigan

8a WAS DECEDENT A U.S. VETERAN? yes

8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946

9a PLACE OF DEATH (Check only one. See instructions.): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution, give street and number): St. Margaret Hospital

9c CITY, TOWN, OR LOCATION OF DEATH: Hammond

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Ellie Blumenhagen

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Foreman

12b KIND OF BUSINESS/INDUSTRY: Amoco

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN, OR LOCATION: Hammond

13d STREET AND NUMBER: 3923 Torrence Avenue

13e ZIP CODE: 46327

13f INSIDE CITY LIMITS: [ ] No [X] Yes

13g ON A FARM? [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY? U.S.A.

15 WAS DECEDENT OF HISPANIC ORIGIN? [X] No [ ] Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)

16 RACE—American Indian, Black, White, etc. (Specify): White

17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

**PARENTS**

18 FATHER'S NAME (First, Middle, Last): William Bryson

19 MOTHER'S NAME (First, Middle, Maiden Surname): Francis Weidman

**INFORMANT**

20a INFORMANT'S NAME (Type/Print): Mrs. Ellie Bryson

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3923 Torrence Ave. Hammond, IN 46327

20c Relationship: Wife

**DISPOSITION**

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) [ ] Entombment

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 10, 1990 Chapel Lawn Memorial Gardens

21c LOCATION—City or Town, State: Schererville, Indiana

22a EMBALMER'S NAME: John C. Ault

22b EMBALMER'S LICENSE NO: FD01013507

23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: John C. Ault

24b LICENSE NUMBER (of Licensee): FD01013507

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Bocken Funeral Home, Inc. FD83002801, 7042 Kennedy Ave. Hammond, IN 46323

**CAUSE OF DEATH**

26 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. ACUTE CONGESTIVE HEART FAILURE — Approximate Interval Between Onset and Death: 2 days
DUE TO (OR AS A CONSEQUENCE OF):
b. CHRONIC CARDIOMYOPATHY — 10 months
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions if any which gave rise to the immediate cause stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: DIABETES MELLITUS

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): no

28a WAS AN AUTOPSY PERFORMED? (Yes or no): no

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): NO

**CERTIFIER**

29a CERTIFIER (Check only one):
[X] CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated
[ ] HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated
[ ] CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

29b SIGNATURE AND TITLE OF CERTIFIER: Claude E. Foreit D.O.

29c MEDICAL LICENSE NO.: 209

29d DATE SIGNED (Month, Day, Year): February 9, 1990

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): C.E. Foreit, D.O. 3831 Hohman Avenue, Hammond, Indiana 46327

**HEALTH OFFICER**

31 HEALTH OFFICER'S SIGNATURE: Franklin D. Penuela M.D.

32 DATE FILED (Month, Day, Year): FEB 09 1990

**CORONER ONLY**

33 MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide

34a DATE OF INJURY (Month, Day, Year):

34b TIME OF INJURY:

34c INJURY AT WORK? (Yes or no):

34d DESCRIBE HOW INJURY OCCURRED:

34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify):

34f LOCATION (Street and Number or Rural Route Number, City or Town, State):

34g DATE PRONOUNCED DEAD (Month, Day, Year):

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

FILED
DEC 11 1990
STATE OF INDIANA
LAKE COUNTY
AUDITOR LAKE COUNTY

900 COMM 33

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

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